Gary Cohen's Hearing
"2014: Seeking PPACA Answers"
Before
Energy & Commerce Committee
Oversight & Investigations Subcommittee

January 16, 2014

Attachment 1—Additional Questions for the Record

The Honorable Cory Gardner

1. **According to a 2012 Report issued by HHS, "[Congressional Budget Office] did not score the impact of risk corridors and assumed collections would equal payments to plans and would therefore be budget neutral." [Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F), Regulatory Impact Analysis, March 2012]**

    a. **Was the intention of the risk corridor program to be budget neutral?**
    b. **What is the expected cost now?**

Answer to 1a & b: Section 1342 of the Affordable Care Act directs HHS to establish a temporary risk corridors program during the years 2014 through 2016.The overall goal of the temporary risk corridor program is to help stabilize health insurance premiums during the transitional period of the first few years of the coverage expansion.

Risk corridors will help protect against potentially inaccurate rate-setting by sharing risk on allowable costs between CMS and qualified health plans. Many people enrolling in coverage through the Marketplace are people who were previously uninsured and health plans have little or no data to predict the future services needs of these enrollees and estimate premiums. These unknowns may result in some plans being underpriced, and others overpriced. This temporary program stabilizes premiums while issuers gain more experience in competing in the Marketplace, and are able to price their plans accordingly.

The estimate for the Risk Corridors program in the President's FY 2014 Budget shows net zero costs over the course of the program, reflecting that the program has been estimated to pay out the same amount of money as it collects from health insurance issuers.

2. **On November 14, 2013, President Obama announced a new transitional relief policy for 2014 under which individuals and small businesses whose insurance coverage had been or would be cancelled under the Affordable Care Act would be able to keep their coverage for an additional year. This announcement was made after insurance companies set their rates for 2014. Did the administration assess the potential impact of**

this new policy on the risk corridor program? If so, what were your findings? If not, why not?

3. **In a December 19, 2013 letter from HHS Secretary Kathleen Sebelius to Sen. Mark Warner, the Administration changed the rules again by allowing people whose policies had been cancelled because of the Affordable Care Act's new requirements to purchase catastrophic plans, which were previously restricted to people under 30 or those who qualified for a hardship exemption. Did the administration assess the potential impact of this new policy on the risk corridor program? If so, what were your findings? If not, why not?**

4. **A November 14, 2013 letter from CMS to state insurance commissioners states: "Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance."**

    a. **What modifications to the risk corridor program are expected?**

    b. **How much will these modifications cost?**

    c. **Based upon the new situation, do you expect to seek a score from the CBO?**

    d. **If there is a systemic failure of the health insurance industry, will the risk corridor program be used to bail out the industry?**

Answer to #s2-4: As a part of the proposed 2015 HHS Notice of Benefit and Payment Parameters,[1] we announced that we are considering a number of approaches to potentially mitigate the potential effects, if any, of this transitional policy, including a proposal for an adjustment to how administrative costs and profits are calculated under the risk corridors program.

The Honorable Bruce Braley

1. **Section 2706(a) of the Affordable Care Act prohibits health insurance plans from discriminating against entire classes of licensed and certified health care professionals on the basis of the provider's licensure or certification. This provision helps to ensure that patients have access to the care they need when and where they need it.**

    Unfortunately, CCIIO released a flawed FAQ on the provision ahead of its 1/1/14 implementation date and some states are now being forced to improperly implement Section 2706 based on CCIIO's flawed FAQ. The underlying problem is that an FAQ is now dictating policy that is different than both the intent of the provision and the language that Congress passed and the President signed into law.

[1] http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf

May I receive your assurance that action will be taken by CMS to rectify this situation and that you will direct the Center for Consumer Information and Insurance Oversight to immediately work with the Department of Labor and Department of Treasury to withdraw and rescind this flawed FAQ guidance? May I also receive your assurance that you will, after rescinding the guidance, alert health insurers and states to the fact that CCIIO has withdrawn the flawed FAQ?

Answer: The statutory language of section 2706(a) of the Public Health Service Act is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of section 2706(a) using a good faith, reasonable interpretation of the law.

The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. **Is there a set date for completion of the back end of the Federally Facilitated Marketplace (FFM)?**

Answer: We're working closely with issuers through a systematic and meticulous process to ensure consumers are correctly enrolled.

2. **How much money has been budgeted for advertisements during the Olympics? Where is this funding coming from?**

Answer: We are spending $4.4 million during the Olympics, as part of the larger Weber Shandwick contract. Ads will run in the markets with the highest rates of uninsurance.

The Honorable Michael C. Burgess

1. **Please provide us with any additional information you have regarding the build of the back end, as well as the provider payments portion of HealthCare.gov i.e. the percentage of payments that have been processed.**

Answer: We're working closely with issuers through a systematic and meticulous process to ensure consumers are correctly enrolled.

2. **Please provide the Committee with any communications regarding ongoing discussions that are happening between you and OMB with regard to seeking appropriation for the risk corridor language in the law.**

Answer: I have not been in communication with OMB with regard to seeking appropriations language for the risk corridor program.

3. **Please provide any legal memorandum that has been prepared for you or your department regarding the risk corridor adjustment and whether that money will be coming from taxpayer dollars or funds that have already been appropriated for the Affordable Care Act.**

Answer: The Department of Health and Human Services has not prepared legal memoranda on this topic at this time.

4. **Please provide any legal memorandum that you have been advised of or briefed on that defines the authority under the Affordable Care Act to delay implementation or the authority to exercise enforcement discretion over enforcement provisions.**

Answer: The Department of Health & Human Services has not prepared legal memoranda on this topic.

The Honorable Marsha Blackburn

1. **You testified that you are receiving regular and detailed briefings. Can you please quantify those briefings and list what types of briefings you are having?**

Answer: I receive regular and detailed briefings on an ongoing basis regarding a variety of policy and operational issues. These briefings are conducted through a variety of means, including in person, teleconference, and by phone.

The Honorable Gregg Harper

1. **Please provide us with a complete list of the staffers who perform any services connected to the risk corridor program.**

Answer: As Director of CCIIO, I over see the risk corridor program.

2. **Please provide the Committee with information regarding the total amount of money that you paid each insurer in this first group of payments that you mentioned during the hearing.**

Answer: The first payments to issuers are expected to begin next week. Payments to issuers are ultimately disbursed by the Department of the Treasury, after being processed through the CMS financial management system. We expect the first payments to be relatively small since they only cover individuals eligible for tax credits and cost sharing reductions who enrolled prior to December 15th.

The Honorable Pete Olson

1. **Please provide the Committee with a copy of the instructions you issued to Navigators telling them that they should not engage in door-to-door solicitation.**

Answer: As a part of the CMS Navigator Grantee Guide issued on September 20, 2013, grantees were instructed that "outreach activities should not include door-to-door activities to help consumers fill out applications or enroll in health coverage." The Committee has posted a copy of the guide on its website.[2]

[2] http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/20130920Final-CMS-Navigator-Grantee-Guide.pdf

The Honorable Cory Gardner

1. **Please provide the Committee with any legal opinions or memorandums that gave the President the authority to mandate insurance companies to allow their members to keep current plans through 2014.**

Answer: The Department of Health & Human Services has not prepared legal memoranda on this topic.

2. **How many small business insurance plans do you anticipate being canceled?**

Answer: The small businesses market for health insurance differs from the individual market; small businesses enroll, renew, or drop their insurance plans throughout the calendar year. Many small businesses renewed their plans in late 2013 and will be making decisions this year on the future coverage.

3. **How many people who signed up in the exchanges were not previously insured? How many were previously insured but had their insurance canceled and are now signed up in the federal exchange?**

4. **How many individuals saw their insurance rates go up after signing up in the federal exchange?**

5. **Of the supposed 45 million people without insurance, how many people now have insurance?**

Answer for #s 3-5: Our most recent enrollment report shows that nearly 2.2 million people have enrolled in a private health insurance plan through the Federal and State-based Marketplaces since October 1,[3] and in October and November, 3.9 million individuals learned they are eligible for coverage through Medicaid and CHIP.[4,5] We expect these numbers to continue to grow because (1) open enrollment continues through March; (2) special enrollment periods are available for those with a change in circumstance; and (3) eligible individuals can enroll in Medicaid throughout the year.

The premiums being charged by insurers provide clear evidence that the Marketplace is encouraging plans to compete for consumers, resulting in more affordable rates. The weighted average premium for the second-lowest-cost silver plan, looking across 47 states and DC, is 16 percent below the premium level implied by earlier Congressional Budget Office (CBO) estimates.[6] Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that, "while premiums will vary significantly across the country, they are generally lower than expected," and that fifteen of the eighteen states examined would

[3] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf
[4] These numbers include new eligibility determinations and some Medicaid and CHIP renewals.
[5] http://www.hhs.gov/healthcare/facts/blog/2013/12/nationwide-enrollment-surges.html
[6] http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib_marketplace_premiums.cfm#_ftnref18

have premiums below the CBO-projected national average of $320 per month for a 40-year-old in a silver plan.[7]

The Honorable Bill Johnson

1. How many contractors are involved and dedicated to the security of HealthCare.gov?

Answer: The privacy and security of consumers' personal information are a top priority for the Department. When consumers fill out their online Marketplace applications, they can trust that the information they are providing is protected by a comprehensive set of security standards and practices. Security testing happens on an ongoing basis using industry best practices to appropriately safeguard consumers' personal information. The components of the FFM that are operational have been determined to be compliant with the Federal Information Security Management Act, based on standards by the National Institutes of Standards and Technology and on those promulgated through OMB. Additionally, all of CMS's Marketplace systems of records are subject to the Privacy Act of 1974 and the Computer Security Act of 1987.

Security is a consideration throughout the software development process, so a variety of contractors that have contributed to the developed of the Federally-facilitated Marketplace have also contributed to its security. CMS has used other contractors for certain security specific tasks.

2. How much money is being spent to provide security to HealthCare.gov?

Answer: As of October 31, 2013, total IT cost outlays total $319 million. This total includes funds spent on Healthcare.gov. As security controls are integrated into overall IT activity, we are not able to single out funding for security specifically.

3. During the hearing you stated that you are given reports on the security of HealthCare.gov. Please provide the Committee with examples of those reports so we can see what those reports include.

Answer: Independent security testing on the Federally-facilitated Marketplace (FFM) with written audit reports known as Security Control Assessments is a robust and ongoing progress. In addition to regular independent security testing, ongoing security testing is conducted using industry best practices. This ongoing security testing include weekly penetration testing, ongoing monitoring by sensors and other tools to deter and prevent unauthorized access, and scanning by automated tools for vulnerabilities. These continuous and weekly tests are reported to CMS security experts.

CMS treats these reports, in accordance with guidance from the National Institute of Standards and Technology, as sensitive, protected information that is highly confidential because they contain detailed information about the Agency's information systems, and the disclosure of this information could put the systems and personally-identifiable information at risk.

[7] http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf

The Honorable Billy Long

1. **Please provide the Committee with the data that breaks down the total number enrollees into the number of people who were previously uninsured versus the number of people who may have been insured before the Affordable Care Act implementation and have since switched to new coverage.**

Answer: Our most recent enrollment report shows that nearly 2.2 million people have enrolled in a private health insurance plan through the Federal and State-based Marketplaces since October 1st,[8] and in October and November, 3.9 million individuals learned they are eligible for coverage through Medicaid and CHIP.[9,10] We expect these numbers to continue to grow because: (1) open enrollment continues through March; (2) special enrollment periods are available for those with a change in circumstance; and (3) eligible individuals can enroll in Medicaid throughout the year.

The Honorable Renne Ellmers

1. **Of the 3.9 million who have enrolled in Medicaid, how many of them could have previously signed up for Medicaid but did not do so before the Affordable Care Act was implemented?**

Answer: HHS has released data on Medicaid determinations and assessments over the last few months. These data are from various enrollment channels, including Federal and state Marketplaces, as well as state Medicaid and CHIP agencies. We will gain additional understanding on newly eligible Medicaid and CHIP enrollments as states report additional data in the future.

Later this year, States will begin to report to CMS quarterly data on new enrollments under the Affordable Care Act to receive their 100 percent Federal funding for people newly eligible under Medicaid expansion. We will then learn more information about the number of newly enrolled individuals who would have been previously eligible prior to the Affordable Care Act.

[8] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf
[9] These numbers include new eligibility determinations and some Medicaid and CHIP renewals.
[10] http://www.hhs.gov/healthcare/facts/blog/2013/12/nationwide-enrollment-surges.html